

## Quitting smoking: challenges and the way forward in the Indian scenario

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Tobacco smoking is the second most common risk factor for diseases worldwide and in South Asia<sup>1</sup>. Each year tobacco kills about 1 million Indians<sup>2</sup>. If the current trends continue, by 2020 tobacco will account for 13% of all deaths<sup>3</sup>. Quitting smoking is the single most important step a smoker can take to improve the length and quality of his/her life. In order to reduce tobacco-related deaths and morbidities, current users must quit smoking. However, quitting smoking can be tough due to the addictive nature of nicotine. Also, high rates of relapse occur among quitters due to the addiction potential of nicotine<sup>4</sup>. Thus governments need to encourage smokers to quit and provide assistance by formulating smoker-friendly policies.

### History of tobacco cessation activities in India

Tobacco cessation efforts in India began in the context of primary, community-based interventions for cancer control in the 1980s and 1990s (ref. 5). This was followed by widespread health education using mass media, screening of films, posters and personal communication which has led to decline in tobacco use and increased quit rates. In 2002, 13 tobacco cessation clinics (TCCs) were set up to provide the first formal cessation intervention in India<sup>5</sup>. They aimed at devising treatment approaches for dependence, generating experience and studying the feasibility of implementation of the cessation intervention model. TCCs provide tobacco cessation services in the form of behavioural counselling, pharmacotherapy and a combination at both the clinical and community levels and serve as tobacco control resource centres for each state by providing technical support, training and other services.

However, tobacco control efforts in developing countries such as India have mostly concentrated on advertising bans, package labelling, prohibition of smoking at public places and raising taxes. Such policies encourage the social norm

of non-smoking and increase the demand for cessation services. Poor cessation services will thus lead to more relapses and failed quit attempts. Smoking cessation is a priority in low-income countries to reduce disease burden, reduce poverty and spur economic development, according to the Commission on Macroeconomics and Health<sup>6</sup>. However, despite strong evidence-based strategies smoking cessation is not necessarily approached as a key tobacco-control strategy. According to the Global Adult Tobacco Survey (GATS), 2010, 38% of smokers made an attempt to quit in the previous 12 months, but only 9% of smokers used counselling and only 4% used pharmacotherapy<sup>7</sup>.

### Evidence-based smoking cessation services

Behavioural therapies ranging from simple advice offered by a physician or a healthcare provider to a much elaborate therapy by a counsellor have been shown to be efficacious<sup>8</sup>. Simple advice from a physician has been shown to increase abstinence rates significantly (by 30%) compared to no advice<sup>9</sup>.

Group counselling at the workplace was found to be an efficient method of smoking cessation<sup>10</sup>. Mishra *et al.*<sup>11</sup> developed a successful comprehensive model workplace tobacco cessation programme offering group counselling and pharmacotherapy reinforced by phone calls and quit tobacco messages in a chemical industry in rural Maharashtra. This model can be replicated at other workplaces and communities across the country.

Quitlines are a free, flexible, telephone-based tobacco cessation counselling services that offer help to quit smoking. Quitline counselling more than doubles a smoker's chances of quitting, whereas quitline combined with medication (Nicotine Replacement Therapy (NRT)) can triple the chances of quitting<sup>11</sup>. Quitlines are a cost-effective and efficient way of reaching a large number of smokers, reducing access barriers and serving as a gateway to other cessation resources<sup>12</sup>.

All the commercially available forms of NRT are effective as part of a strategy to promote smoking cessation, increasing the odds of long-term quitting approximately 1.5 to 2-fold regardless of the setting<sup>13</sup>. Several studies and meta-analysis have found that varenicline, bupropion and the five nicotine replacement therapies (gum, inhaler, nasal spray, tablet and patch) were more efficacious than placebo<sup>14</sup>. However, selecting a particular type of pharmacotherapy should be guided by evidence, patient preference, experience, history, needs, dependence, clinical suitability and drug side effects/interactions<sup>15</sup>. Combination pharmacotherapy is indicated for patients based on failed attempt(s) with monotherapy, breakthrough cravings, level of dependence, multiple failed attempts and patients with nicotine withdrawal. While prescribing combination pharmacotherapy, different forms of NRT should be first selected and then a combination of bupropion and NRT can be prescribed<sup>15</sup>.

'Quit and Win' is a cost-effective, evidence-based smoking cessation method for population-based public health approach<sup>8</sup>. There is also some evidence that a text message-based intervention can double quit rates. It offers a new way to address the unmet need for smoking cessation intervention among young adults with advantages of being affordable, personalized, age-appropriate and having a wider reach<sup>16</sup>.

### Challenges in the Indian context

High prevalence of smoking among health professionals and lack of motivation of healthcare providers is a major barrier to implementing cessation services in the healthcare system since health providers are key to implementing cessation programmes. Inadequate training of healthcare providers to deliver effective cessation interventions is a major deterrent as well. Health care professionals usually do not enquire about history of smoking in the patient as they are not sensitized regarding the impact of smok-

ing habit on health and disease and the benefits of smoking cessation.

Lack of resources and Government funding for the implementation of effective smoking cessation interventions pegs the agenda backwards. Lack of availability, accessibility and affordability of pharmacotherapy products puts them beyond the reach of the smokers.

Also, India does not have the infrastructure to provide cessation treatment for tobacco users who want to quit. India lacks well-established clinics and quitlines. There is a gross lack of counselling during patient–physician interactions<sup>17</sup>. According to GATS, less than half the smokers were advised to quit by their healthcare providers, which is even lower (27%) for users of smokeless tobacco<sup>7</sup>.

### Way forward

Trained human resource to provide tobacco cessation is a major challenge. The medical, dental and nursing curricula should address counselling techniques, cessation pharmacotherapy and be reinforced with practical training during patient interactions. To sustain tobacco control initiatives in India, Samet felt that there are immediate and long-term needs for capacity development in the country<sup>18</sup>. The role of trained community health workers in implementing tobacco control policies in resource-poor settings like India can be crucial in curbing the tobacco epidemic. A modular training of health workers about tobacco control conducted in two jurisdictions of India, namely Chandigarh and Hamirpur district in Himachal Pradesh produced encouraging results<sup>19</sup>. Eliciting smoking history must be a routine component of history taking. Every healthcare provider must use the contact as an opportunity for assessing smoking behaviour and promoting behaviour change.

Despite strong evidence, smoking cessation pharmacotherapy is grossly underutilized with only one out of five smokers using drug therapy when making an attempt to quit<sup>20</sup>. NRT should be made easily accessible and subsidized. Decreasing the out-of-pocket costs for cessation treatment increases quit attempts and the number of successful quitters<sup>21</sup>. Thus, we should be thinking along the lines of Sri Lanka and Thailand, where health insurance or the National Health Service supports the cost of cessation.

Mass media should be promoted vigorously to advertise the benefits of smoking cessation and availability of cessation services nearby. This will also provide social support to the individuals who want to quit. A quitline should be initiated to provide free counselling and other resources to quit, and to prevent relapse for those who have already quit smoking.

We should pursue further research towards developing evidence-based interventions for different settings through tobacco cessation clinics. However, considering the limited impact of targeted tobacco cessation clinics in the US<sup>18</sup> and financial constraints, it might be more cost-effective and feasible for developing countries to integrate smoking cessation into other healthcare programmes like tuberculosis, cancer control or Non Communicable Disease control<sup>22</sup>. Tobacco cessation services should be integrated with the primary healthcare. It requires training of health professionals on cessation counselling and pharmacotherapy, access to low-cost pharmacological therapy by including it in the essential drug list of health facilities at various levels and raising community awareness about cessation services available.

### Conclusion

India has many assets as it faces these challenges. The vast network of healthcare delivery system, millions of healthcare providers, effective tobacco control leaders and advocates should be capitalized as the country moves towards meeting its Framework Convention on Tobacco Control obligations. The National Tobacco Control Programme should be strengthened to support the incorporation of tobacco control efforts into the existing healthcare system.

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